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ABSTRACT

This practicum was designed to increase the self-esteem of children between the ages of 8 and 12 from dysfunctional families. The strategies implemented involved working with the parents of these children to help increase positive communication and relationships between parents and their children. Based on the idea that self-esteem is a reciprocal process developed in language between people, this study focused on changing styles of communication between parent and child. An 8-month parent-education group combining several educational programs was developed to help parents of six children focus on fostering positive communication in their children. A one-way mirror was used by the parents to observe their children participating in a self-esteem group, after which the parents joined their children in the group and offered them encouragement, praise and comments focusing on positive behaviors they had observed. The Piers Harris Children's Self Concept Scale was administered before and after the practicum--along with observational check lists and structured interviews with the parents--to compare the children's levels of self-esteem. Data revealed increased eye contact and better parental perceptions in regard to improved eye contact and social skills in the children. The Piers Harris Scale revealed a highly significant increase in the self-esteem of the children. Checklists and interviews are appended. (Contains 30 references.) (Author/KW)

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ED 387 729

Increasing Self Esteem in Children, 8-12 Years Old from Dysfunctional Families: A Twofold Solution to a Twofold Problem

by

George M. Riley

Cluster 47

A Practicum Report Presented to the
Ed.D. Program in Child and Youth Studies
in partial fulfillment of the Requirements
for the Degree of Doctor of Education

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by George M. Riley under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Child and Youth Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

-Approved

June 5, 1995
Date of Final Approval of Report

June S. Delano
June Delano, Ph.D.

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The writer wishes primarily to thank Joan Cassens, LMHC, the counselor who facilitated the children's pre-adolescent group while the writer worked simultaneously with the parents of these children in the parent education group; without her valuable input and initiative this practicum could not have been accomplished. The writer would also like to thank Neil Gawlak, Outpatient Director, whose support, encouragement and praise initiated interest in this practicum in the writer's workplace. Grateful appreciation is extended to Benjamin Quiambao, M.D., former Medical Director of Adult and Adolescent Psychiatry, who initially acted as verifier of this practicum. The writer also extends his gratitude to Carmen Ebalo, M.D., who happily volunteered to act as the final verifier of this practicum when Dr. Quiambao left the hospital to devote more time to his private practice. Most profound gratitude goes to the children, parents, staff, and administration who cooperated in the implementation of this practicum. Last, but certainly not least, the writer would like to thank Janice M. Hackett for her many hours of editing and typing this manuscript.

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ABSTRACT

Increasing self esteem in children, 8-12 years old, from dysfunctional families: A twofold solution to a twofold problem. Riley, George M., 1995: Practicum Report, Nova Southeastern University, Ed,D. Program in Child and Youth Studies. Mental Health/Children, Youth and Families/ Self Esteem in Children/Parent Education/Group Counseling.

This practicum was designed to increase the self esteem of children between the ages of 8 and 12 from dysfunctional families in a private psychiatric outpatient clinic. The strategies implemented involved working with the parents of these children to help increase positive communication and relationships between parents and their children. Based on the idea of social constructivism that self esteem is a reciprocal process developed in language between people, this practicum involved changing styles of communication between parent and child.

The writer developed an eight-month parent education group combining several parent education programs, modifying them to focus on fostering positive communication. A one-way mirror was used by the parents to observe their children participating in a self esteem group after which they joined their children in the group and offered them encouragement, praise and comments which focused on positive behaviors they had observed. Audio and video tapes of scenarios which demonstrated positive communication were used and homework was assigned. The Piers Harris Children's Self Concept Scale was administered before the practicum; upon completion of the practicum it was readministered for purposes of comparison along with observational check lists and structured interviews with the parents.

Analysis of the data revealed increased eye contact and better parental perceptions in regard to improved eye contact and social skills in their children. The Piers Harris Children's Self Concept Scale revealed a highly significant increase in the self esteem of the children.

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CHAPTER I

INTRODUCTION

Description of the Community

The work setting in which this practicum was conducted was a private, outpatient clinic operating under the auspices of a community psychiatric hospital. This small, but rapidly growing, clinic was located in a rural coastal community in the southeastern United States. The clinic consisted of a staff which included: a clinical director who was a licensed mental health counselor; two medical directors, both psychiatrists (one to work with children under the age of twelve years and one to work with children older than twelve years and adults); a third psychiatrist who saw children older than 12 years and adults; one staff therapist; another licensed mental health counselor; an office manager; three part-time receptionists; and eight privately contracted non-staff therapists, called the Allied Health Staff.

The eight therapists on the Allied Health Staff possessed diverse backgrounds and training in the field of mental health which brought multiple perspectives to how they perceived and worked with children and their problems. The various areas of specialization and disciplines in the mental health field embraced by the therapists on the Allied

Health Staff included: two licensed marriage and family therapists; a licensed psychologist; three licensed mental health counselors; and two licensed social workers. The academic degrees held by these therapists ranged from the level of master to that of doctorate and included: Master of Education; Master of Social Work; Master of Psychology; and Doctor of Psychology. About 90% of the clinic's caseload consisted of young children, pre-adolescents, adolescents, and families; the families were mainly single parent families, married couples with children, and foster families. Approximately 50% of these families were at the lower end of the socioeconomic scale and depended on public welfare as their main source of income. This practicum dealt specifically with children between the ages of eight and twelve years old and their parents.

All referrals to the clinic were first evaluated through the access center of the main psychiatric hospital; the access center consisted of intake workers who evaluated and diagnosed the mental state of people who presented with problems. The access center would determine the appropriate therapist for the diagnosed condition and refer to the outpatient clinic. Referrals screened through the access center and referred to the outpatient clinic originated from: the public school system, the psychiatric hospital, Spouse Abuse, local physicians, Health and Rehabilitation Services (HRS), employee assistance programs (EAP's),

private insurance companies, the legal system, the yellow pages, and various marketing techniques utilized by the hospital. Because of its diverse referral sources, the clinic dealt with a wide range of mental and emotional problems presented by individuals from many different cultures and backgrounds within the community.

Writer's Work Setting and Role

The writer's role in the outpatient clinic was that of a licensed marriage and family therapist specializing in the treatment of children from infancy through young adulthood and their families. In the writer's workplace there were only five therapists credentialed by the hospital to work with children. Two of these five therapists worked exclusively with adolescents over twelve years of age; the remaining three therapists worked primarily with young children and adolescents. The writer worked with both young children and adolescents and was supervising another therapist, credentialed only to work with adolescents, towards accreditation in working with young children also.

Like other members of the Allied Health Staff, the writer contracted privately with the outpatient clinic to provide services. As previously mentioned, appointments were scheduled by the access center through the office manager and the three receptionists. With the exception of group sessions which lasted one and a half hours,

appointments were scheduled on an hourly basis from 9:00 o'clock a.m. to 8:00 o'clock p.m. Monday through Friday. This writer contracted for eleven hours per day, three days per week and five hours on Friday for an average caseload of 38 hours per week counseling children and families. In addition to working with children and families, the writer conducted a weekly play therapy group for children between the ages of seven and fourteen years of age.

Many times, other therapists would come to the writer, an Approved Supervisor of the American Association for Marriage and Family Therapy (AAMFT), for impromptu case staffings. The writer would also refer clients needing more intense individual work to other therapists in addition to making psychiatric referrals.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

The situation at the outpatient clinic which needed improvement concerned the lack of self esteem on the part of children, aged eight through twelve, from dysfunctional families. The writer had observed that the majority of children, aged eight through twelve, from dysfunctional families who presented for counseling suffered from low self esteem. Many different treatment modalities had been utilized with these children to help increase their self esteem, including: group counseling, individual counseling, family therapy, and parenting classes. Perhaps, for this therapist, one of the most frustrating experiences of working with this particular population involved the high rate of recidivism. Even after implementation of the above treatment modalities, many of these children would return to counseling suffering again from low self esteem.

In addition to the high rate of recidivism among this group, the writer had experienced problems in working with their families. In treating entire families of children, aged eight through twelve, from dysfunctional families, one or both parents would often fail to participate. It would appear that the parents preferred treatment which focused on

the child. In treating the entire family, it became clear that parents and siblings usually perceived the problematic child as the disrupter of the family and so failed to take any personal responsibility for problems within the family. The language directed toward the child by the family tended to be quite negative and this writer observed that, after a period of time, the child actually regarded himself as "bad"; feeling unable to do anything right, the child became apathetic to change and acting out behavior would continue.

Once children in this population had been treated and their self esteem increased, too often they would return to the former context of their lives. This writer also observed that if the family had not changed its patterns of interaction, the familial system would once again organize the problems of the family around the child; subsequently, this "scapegoating" resulted in lowering the child's self esteem even further. It appeared quite evident to this writer that the parents of children, aged eight through twelve, from dysfunctional families who presented for counseling lacked sufficient education in positive, effective parenting skills.

Another aspect of the problem involved the child either approaching or beginning early adolescence. Due to the fact that in the cultures of most countries, including America, early adolescence occurs between the ages of ten and thirteen years, the period between eight and twelve years is

especially difficult for many children; during this time children in this age group begin to experience physical, hormonal, and emotional changes which often prove confusing and upsetting to them (Santrock, 1993; Santrock and Yussen, 1992; and Schickendanz, Hansen and Forsyth, 1990). One can easily understand that during this period of turmoil children are particularly sensitive to criticism from others, especially their parents. Considering these factors in regard to influencing the behavior of children, it appeared to be true that children, aged eight through twelve years, from dysfunctional families who presented for counseling at this writer's workplace suffered from low self esteem.

Problem Documentation

Determining that children, aged eight through twelve years, from dysfunctional families who presented for counseling suffering from poor self esteem actually constituted a serious problem required gathering evidence locally. This involved interviewing the clinical director and several other colleagues credentialed by the hospital to work with children. All those interviewed by the writer designated poor self esteem in children as constituting a primary problem in the outpatient clinic. These clinicians expressed particular frustration concerning the fact that, even after treatment, these children would often return as

soon as six months after release, suffering from the same problems, including low self esteem.

Furthermore, in addition to identifying poor self esteem in children as a major problem, the staff members interviewed by this writer also acknowledged that, according to their own observations, in most cases the parents of these children also suffered from low self esteem. Other evidence that children, aged eight through twelve, from dysfunctional families who presented for counseling suffered from low self esteem lay in the fact that every treatment plan completed by those interviewed, as well as by this writer, cited poor self concept as one of the documented symptoms in this population.

Causative Analysis

The majority of referrals to the outpatient clinic consisted of children, youth, and families. When a child presented for counseling suffering from low self esteem, the initial consideration of possible causes had to take into account the context in which the problem was embedded. Many children presented for counseling with histories of abuse and/or neglect, alcoholic or substance abusing family members, divorced parents, custody battles, abandonment, poor socioeconomic status, and various combinations of these circumstances. In addition to the above-listed probable causes, these children had oftentimes inherited genetic

traits, such as: bipolar disorder; depression; attention deficit disorder, with or without hyperactivity (ADD and ADHD); schizophrenia, and personality disorders. Often the various causes for their behavior were discounted the children were simply labeled as "bad." When a child acts out the symptomology of one psychological disorder, or a combination of several, the caregivers will often criticize and punish the child until that child begins to believe that he/she is bad, resulting in the creation of a self-fulfilling prophecy.

This practicum briefly examines the following principal causes of low self esteem in children, aged eight through twelve years, from dysfunctional families:

1) In every case this writer dealt with which concerned a child as the identified patient, interviewing the parents during the initial evaluation revealed a negative interactional pattern between parent and child. Often parents would blame or "scapegoat" the child as the principal cause of problems within the family. Parents were quick to point out the problem, relating chiefly negative observations about the child who usually tended to internalize this conversation. The child would think that the parents or caregivers perceived the child as "bad"; once the child accepted their premise that

he/she was "bad" the child felt powerless to change. This resulted in the child thinking poorly of him/herself and continuing to act out of this belief.

2) In family therapy, the family would usually have discovered some solutions to their problems and the situation may have improved temporarily to some degree; however, most parents still lacked skills in praise, effective communication, problem solving, parenting, intimacy, and nurturing. If these deficiencies were not addressed in some way, the family would eventually regress to the same level of functioning as before therapy and the child's self esteem would continue to be low.

3) Once new skills were learned dealing with positive interaction between parent and child, due to the artificiality of the context (the clinic) the parents had no way of practicing new behaviors in front of the therapist. Therefore, the therapist was not in a situation conducive to coaching and providing feedback to the parents on implementing their newly learned skills. Thus these newly-learned, interactional skills may have been taken home and applied wrongly or in a distorted way, causing frustration on the part of the parents or guardians. Once frustrated, they often abandoned

their newly learned skills, perceiving them to be ineffective; some even dropped out of therapy altogether with the attitude that "it just doesn't work."

Relationship of the Problem to the Literature

Other professionals have written numerous articles and books which provide much insight into the problem of low self esteem in children and adolescents. To start, Santrock and Yussen (1992) defined self esteem as the affective and evaluative dimension of the self concept, otherwise referred to as self worth or self image. Self esteem is that aspect of self concept which takes into account how individuals feel about themselves and perceive themselves as they think that others perceive them.

A study by Schilling (1986) outlined four components which comprise self esteem:

1) a feeling that the person is capable;
2) a sense of significance to others;
3) confidence that the person has the ability to determine how to live; and
4) a sense of uniqueness and a feeling that the person is worthwhile in his/her own right.

In determining an accurate definition of self esteem, perhaps the most important aspects concern how children develop a sense of satisfaction for the person they perceive

themselves to be and whether or not they feel worthwhile and significant to others.

Recent definitions of self esteem surfaced in the work of Social Constructivists, John Shotter, Professor of Communication at the University of New Hampshire and Kenneth Gergen, Professor of Psychology at Swarthmore College. According to Shotter (1985), self esteem is a hermeneutic process in which our concepts of ourselves are revealed to us through language by the many different ways we talk about ourselves to others. Similarly, Gergen (1991) believes that we constitute our self concept through a socially interactive, social constructivist process based on our perceptions of how we perceive others perceive us. In other words, through language with others our sense of self, including self esteem, is socially constructed based on the relationship at the time.

Interestingly, Demo, Small and Saven-Williams (1987) postulated a similar paradigm which they call a symbolic interactionist perspective. More succinctly, they stated that an individual's sense of self is a social product of the reflected evaluations of others which are exchanged in the course of social interactions, particularly those involving the significant others in one's life (Demo et al., 1987). These cognitive theories of social constructivism have interesting implications in that positive social relationships correlate with positive self esteem.

Following that same line of thinking, since parents and their offspring are so important in each other's lives it is logical to assume that perceptions of self are significantly constituted through the parent/child relationship (Demo et al., 1987). Also, since the self-perceptions of parent and child are constructed through their relationships with each other, it is logical to assume that the context in which that relationship occurs is also a major factor. It has indeed been substantiated by Schickedanz, Hansen and Forsyth (1990) that parents provide their children a context in which they can become strong, independent, autonomous adults by providing rational explanations for their actions and by allowing their children to express their own opinions and views. According to Satir (1972), a pioneer in family therapy, high self esteem is the foundation of both positive communication and interaction within the family; because individuals with high self esteem feel worthwhile they are more likely to be honest, responsible, compassionate, and loving toward other family members.

In many families open communication, positive interactions, and high self esteem do exist; but what about families lacking in these traits? According to Kaplan (1976), the reverse is also true: children who exhibit low self esteem are likely to be defensive or depressed and engage in more deviant behavior. Furthermore, according to Leflore (1988), troubled or delinquent adolescents tend to

emerge from families who lack positive communication, strong support from family members, and emotional expressiveness. Moreover, parents in such families tend to be authoritarian in their parenting styles, not allowing their children to experience the natural and logical consequences of their behavior and thereby decreasing the degree of responsibility and autonomy in their children. A study by West (1981) concluded that parents whose verbal interactions consist mainly of harsh criticism, inducement of guilt, or intrusive questions and commands, foster negative attitudes, poor social competence, and low self esteem in their children.

In reviewing this research it would appear that children with high self esteem come from families with high self esteem and children with low self esteem come from families with low self esteem. Apparently, in dysfunctional families a cyclic interaction occurs: when a child acts out of negative self esteem, the parents react by applying even stronger dysfunctional parenting and problem solving skills; the ineffectiveness of these methods leads to frustration on the part of the parents and the further lowering of parental self esteem. Indeed a growing body of research indicates that self esteem is a reciprocal process between children and their parents (Demo et al., 1987; Small, 1988; Felson and Zielinski, 1989; and Schickedanz et al., 1990).

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The writer proposed to accomplish the following goal through this practicum:

> Children, aged eight through twelve years, from dysfunctional families who enter counseling at the writer's workplace will display an increase in self esteem upon completion of this practicum.

Expected Outcomes

Upon completion of this practicum the writer expected the following outcomes and anticipated the following results:

1) The six children identified for this practicum, upon completion of the practicum, will exhibit increased eye contact by making eye contact three or more times with anyone in the group based on clinical observational checklists. (See Appendix A.) Additionally these six children will demonstrate increased eye contact based on the structured interviews with their parents where their parents answer at least "sometimes" on the Likert Scale on all five questions. (See Appendix B.)

2) The six children identified for this practicum, upon its completion, will maintain more positive interactions with family and friends indicating improved social skills based on clinical, observational checklists wherein they demonstrate less than five occasions of negative behavior during the group session. (See Appendix C.) Additionally these six children will demonstrate to their parents improved social skills as indicated by their parents answering at least "sometimes" on all twenty of the structured interview questions. (See Appendix D.)

3) The six children identified for this practicum will demonstrate upon its completion, in writing, that they can list at least three positive attributes about themselves.

4) The six children identified for this practicum, upon its completion, will indicate a five to ten point increase in global self esteem as measured by the Piers Harris Children's Self Concept Scale.

Measurement of Outcomes

The measurement for the first anticipated outcome, increased eye contact, will be based on two components: a clinical, observational checklist and a structured interview with the parents. Children's eye contact will be defined as

the child making direct eye contact with either a peer in the group setting or the group facilitator. This writer will observe the children through a one-way mirror at three fifteen-minute intervals. These fifteen-minute intervals will occur at the beginning, middle, and end of the children's last group session. There will be one observational period upon completion of the practicum. Frequency of eye contact will be counted using the traditional stroke tally method and the total number of the three observational intervals will be added together to give the total number of observed eye contacts during the last group session. These, in turn, will be tabulated to determine whether any increase in eye contact did actually occur (See Appendix A).

Next, during the structured interview, eye contact will be measured based on the parents' perceptions of how often it occurred. The following format will be utilized for the structured interview:

1) The parents of the children identified for this practicum will be told that eye contact is defined as direct eye contact with an individual during the process of speaking or interacting.
2) During the course of the thirty minute interview the parents will be asked five questions concerning their child's frequency of eye contact.

These five questions will be evaluated according to a Likert scale of measurement:

1 = Never

2 = Seldom

3 = Sometimes

4 = Usually

5 = Always

Once the data collected from this interview has been collected, the total scores will be compared to determine any increase or decrease in the parents' perceptions of the child's frequency of eye contact by the parents answering at least "sometimes" on all five structured interview questions. (See Appendix B.)

The second expected outcome, the children will maintain more positive interactions with family and friends indicating improved social skills, will be measured utilizing the same methods listed above: clinical observational checklists and a structured interview with the parents.

The clinical observational checklist will measure the frequency of a list of specific, negative behaviors which should show a noticeable decrease upon completion of this practicum. These negative behaviors are indicative of poor social interactions and poor social skills. A decrease in these negative behaviors will indicate an increase in more positive social interactions. The following is a list of

negative behaviors, along with a definition of each behavior; these behaviors will be counted using the traditional stroke method:

1) Aggression: The aggressive child argues and fights with other children, sometimes forcing his way into games others are playing. This rudely intrusive behavior also includes bullying, bossiness, and bickering.
2) Lack of Cooperation: The uncooperative child has difficulty interacting harmoniously with others and refuses to engage in social activities unless things are done his/her own way.
3) Teasing: This includes name calling and provoking, annoying or harassing others with persistent actions or remarks as well as poking fun at others in a cruel manner.
4) Selfishness: The selfish child does not share with others and tries to dominate activities.
5) Inattentiveness: The inattentive child has trouble listening and often appears indifferent, detached or oblivious to his/her surroundings and preoccupied with self to the exclusion of others.

6) Withdrawal: This child prefers playing alone to socializing with others.

7) Defiance: The defiant child tends to challenge or oppose accepted norms of behavior and rebel against authority.

8) Argumentativeness: The argumentative child tends to disagree with everything and everyone in a disagreeably quarrelsome manner.

9) Lack of Self Control: This child tends to react impulsively to situations with no regard toward consequences.

10) Anger: The angry child is easily provoked or frustrated and often hostile to others.

The children will be observed for these negative behaviors from behind a one-way mirror at three 15 minute intervals during a group session upon completion of the practicum. This observation will occur at the end of the practicum. The number of occurrences of listed negative behaviors will be totalled to determine whether the negative behaviors occurred five times or less. (See Appendix C).

Next, a structured interview with the parents will help measure their perceptions of the impact of participation in the practicum on the positive interactions and improved social skills of their children. These individual 30 minute

interviews with the parents will be conducted at the end of the practicum. The parents will be asked forced choice questions and answers will be based on a five-point Likert scale. Possible choices will include:

1) Never
2) Seldom
3) Sometimes
4) Usually
5) Always

Upon completion of this interview with the parents, the scores will be tabulated to determine whether or not an increase in positive social interactions and social skills did occur by the parents answering at least "sometimes" on all twenty questions. (See Appendix D for questions asked during the parents' interviews.)

The third expected outcome states that the children will demonstrate, in writing, that they can list three positive attributes about themselves. At the end of the practicum, the children will be asked to list at least three positive attributes about themselves with the option of listing more if they prefer to do so. The ability of each child to list at least three positive qualities about himself/herself will indicate a successful completion of this outcome.

The fourth outcome requires that the children indicate a five to ten point increase in their global self esteem as

measured by the Piers Harris Children's Self Concept Scale. In order to identify which children would be eligible to participate in this practicum, each child who presented for counseling was given the Piers Harris Children's Self Concept Scale. Since a score of 50 points is considered average on this scale, only children between the ages of eight and twelve years who scored less than 50 points on total global self esteem were selected for this practicum. Six children meeting this criteria were identified for participation in this practicum. At the conclusion of the practicum, the Piers Harris Children's Self Concept Scale will be readministered to these six children; their final scores will be compared to their original scores to determine whether or not their global self esteem increased at least five to ten points.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Possible Solutions

The problem of poor self esteem in children aged 8-12 from dysfunctional families has perplexed professionals for many years. The fact that these children would be treated for months in individual and group psychotherapy and show marked improvement, only to reappear presenting the same problem after returning to their families of origin, has been a longstanding topic of discussion among professionals. Even treating these children in family therapy where their families have also received counseling has failed to increase the self esteem of these children over an extended period of time.

Reviewing the literature appeared to present a multitude of possible solutions to the problem of poor self concept in children, aged eight to twelve, from dysfunctional families. Felson and Zielinski (1989) suggest that parental support as measured by children's reports effects self esteem. They define parental support as the child's confidence in the encouragement of his/her parents. Furthermore, Felson and Zielinski (1989) state that parental praise effected the self esteem of boys in the study they conducted. Moreover, LeCroy (1988) found that attachments

to parents are significantly related to adolescent well-being and self esteem.

Interestingly, a correlation was emerging here which indicated that a child's self esteem is strongly influenced by the parental unit. This was further substantiated in a study by Dubrow and Lester (1990) who found that the following conditions improved self esteem in children:

1) an emotionally supportive home environment;
2) a family in which the mother tends to be nurturing and communicates well with her children;
3) a family in which parenting styles tend to be authoritative.

Parenting styles are an important factor in shaping a child's behavior. When they include setting close limits, enforcement of those limits, and a respect for the child's rights to make decisions within those limits, the child begins to develop a sense of responsibility which, in turn, increases the child's self esteem.

Parental influence has a marked effect on a child's future. According to Nurmi and Pulliainen (1991), family context and parent/child interaction influence adolescents' orientation toward the future in four ways. Nurmi and Pulliainen (1991) state:

1) Parents influence their children to become interested in different areas of their future, such as education.

2) The parental relationship and the atmosphere it creates can model either a positive or negative idea about the future and can influence the adolescent's decision whether or not to have a family.

3) Adolescents can learn coping strategies and basic planning skills from their interaction with their parents.

4) Family context may influence an adolescent's optimism concerning the future.

Dysfunctional families who lack the above factors tend to be more authoritarian from the writer's observation. Authoritarian parents tend to stifle a child's ability to develop independence which is an important factor in increasing self esteem. In fact, Nurmi and Pulliainen (1991) concluded from their study that adolescents who were less controlled by their parents and encouraged to be independent showed earlier development of life planning.

From those findings it logically followed that programs designed to change parent/child interactions could increase the child's self esteem. This, in fact, has been suggested by LeCroy (1988) who proposes that programs designed to increase parent/adolescent intimacy and relationships would be helpful in increasing children's self esteem. However, could dysfunctional families change their interactions to improve self esteem in their children? A study by Eyberg

and Robinson (1992) concluded that parents of disturbed children can change both their interactional style and the behavior of their children by learning to interact non-directively, giving positive attention, praise, and a minimum of correction and criticism.

It has therefore been demonstrated that when parents changed their interactional patterns with their children, the children's self esteem increased. But what type of behaviors should parents employ to increase their children's self esteem? Searcy (1988) submitted that in order for parents to help develop positive self esteem in their children, they must:

1) help their children feel more capable by providing their children with more responsibility, recognizing their children's talents, and emphasizing the strengths and abilities of their children;
2) help their children feel more significant by listening to their children, helping their children find groups to join, and telling their children that they love them;
3) help their children feel more powerful by teaching their children to make decisions, giving their children some say in their own lives, and allowing their children to make choices from various alternatives;

4) help their children feel more worthy by promoting hobbies, discussing their problems openly with them, and recognizing those inner qualities which make their children special.

Not only can parents teach their children independence and responsibility which will increase their children's self esteem, but other areas such as compassion for others and interpersonal skills can also be transmitted to children through their families of origin. Richards, Gitelson, Peterson and Hurtig (1991) concluded in their study of adolescent personality that mothers who were socialized to be nurturant may contribute more to their children's development of humanistic concerns and interpersonal skills than their fathers. It was interesting to note that gender differences of the parents had an impact on their children. For example, nurturant mothers may have contributed more to certain areas of their children's development than to other areas.

The next logical question concerned the effects, if any, of fathers' involvement on the emerging sense of self developing in their children. A 1984 study on parent/child play by MacDonald and Parke concluded that through playful, physical interaction between children and their parents, particularly their fathers, children may be learning the social communicative impact of their own affective displays, as well as how to use those signals to somewhat regulate the

social behavior of others. More simply, they may be learning how to decode the affective signals of other social partners which will help build self esteem.

Along the same idea that the different genders of the parents affects their different-gendered children, Gecas and Schwalbe (1986) found in a study on parental behavior and adolescent self esteem that self esteem in boys was sensitive to the control/autonomy aspect of parental behavior which appeared to be the more masculine role. On the other hand, like Richards et al. (1991), Gecas and Schwalbe (1986) found that the self esteem of girls was positively affected by parental support and participation or the more nurturant aspect characteristic of mothers.

Many different speculations could be postulated as to why these researchers reached their conclusions. One may be the fact that, to some degree, families still cling to traditional gender roles wherein the mother is more nurturant and involved with the children than the father. That the father cannot be as involved with the children because of the long hours he works has been an established fact for so long that, even though many mothers now work just as many hours, the more familiar conventional roles are difficult to cast off. However any involvement by fathers would also have a strong effect on their children. It is the belief of this writer that as the family moves even more into post-modern society these outmoded gender stereotypes

will become skewed and unclear until eventually such myths will cease to be a part of people's belief systems.

The perceptions of children and adolescents concerning their relationships with their parents have a definite effect on their self esteem. Whether or not the children's perception of reality matches their parents' perception of reality is actually immaterial; as far as the children are concerned the only reality that exists is that which they perceive to be true. This in fact has been substantiated by Barber, Chadwick and Oerter (1992) who concluded in their study that positive self esteem in adolescents correlated significantly with the adolescents' perceptions of their relationships with their parents and was characterized by feelings of security, availability, support, physical affection, and companionship. Similarly, a study by Walker and Greene (1986) on the social context of adolescent self esteem found that the quality of the adolescents' relationships with their parents based on parental support, affection, and encouragement correlated positively with the self esteem of the adolescents. Further studies have revealed social support in the form of affirmation and approbation is correlated to positive self esteem in children. In fact, Hoffman, Levy-Schiff and Ushpiz (1993) pointed out that support in the form of affirmation and approbation boost self esteem and that adolescents tend to

orient themselves toward parents and peers who offer high levels of support.

Finally, concerning what parents can do to help increase their children's self esteem, The National Parents' and Teachers' Association (PTA, 1988) published the following definitive ideas:

1) Of utmost importance in building children's self esteem is good communication by the parents.
2) Parents should encourage their children to develop a positive approach and attitude toward life.
3) Parents should encourage and emphasize responsibility in their children.
4) Parents should encourage their children to set both short and long term goals that are realistic in regard to their own abilities.

The following are some ideas generated as possible solutions to poor self esteem in children from dysfunctional families:

1) Due to accessibility problems in working with the children's school and peer relationships, the most accessible context within which to work available through the outpatient clinic is the children's family. The family could benefit from parent training in praise and encouragement, providing support and nurturance, and setting limits which are consistently enforced.

2) Work with children in a group setting to assess their talents and work these into a program which would be presented to their parents either live or on videotape.

3) Develop scenarios on videotape and have the parents practice particular behaviors in a role playing situation with the clinician acting as a coach or director.

4) Start a parent support group which would be run by the parents to provide a forum or sounding board to express frustrations about their children and find solutions to problems utilizing other parent group members.

5) Have the parents view their children in a self esteem group and teach the parents communication skills (eg., positive connotation and reframing, how to look for and recognize positive behavior, and how to listen). The parents would then reflect this live back to their children and the children would reflect back to the parents what they felt as their parents were speaking to them.

Description and Justification for Selected Solution

Based on the writer's own ideas and information gleaned from the literature regarding the problem of children, aged

eight to twelve years, from dysfunctional families suffering from low self esteem, the following solution was proposed:

The writer selected from four to eight male and female children of various races, aged eight to twelve years, from dysfunctional families whose parents were willing to participate and who met the previously listed criteria for this practicum. One and one half hours of parent training were given weekly to the parents of the children identified for the practicum; this training occurred at the same time that their children were attending group therapy. These dual sessions lasted a total of 32 weeks. Eyberg and Robinson (1982) suggest that the parent/child interaction pattern can be altered positively through parent training.

The parent training classes focused on parent/child interactions, developing positive communication skills, praise of the child, limit setting and consequences, and improving listening skills which would increase the child's self esteem (Eyberg and Robinson, 1982; West, 1981; Felson and Zielinski, 1989; Dubrow and Luster, 1990; Searcy, 1988; Walker and Greene, 1986; and PTA, 1988). The parent training was educational in nature and included lectures, homework assignments, actual role playing, and utilizing videotape to practice positive feedback of the children's behavior. Live observation of the children's group through a one-way mirror allowed practice giving positive feedback, encouragement, and support through conversation with the

children (LeCroy, 1988; Gecas and Schwalbe, 1986; Hoffman, Levy-Schiffman and Ushpiz, 1993; Walker and Greene, 1986; and PTA, 1988).

At the conclusion of the practicum the Piers Harris Children's Self Concept Scale was administered and the results compared with those of the same test administered at the time of intake (Piers, 1984).

The above procedures were expected to work for two reasons. First, through the parent training group, the parents would learn to interact in a different way with their children, emphasizing more positive communication, self esteem in children (Eyberg and Robinson, 1982; West, 1984; LeCroy, 1988; Searcy, 1988; Richards et al., 1991; Barber et al., 1992; and PTA, 1988). Secondly, the Piers Harris Children's Self Concept Scale would give data at intake before the implementation of the practicum and again after implementation to help determine the effectiveness of this strategy (Piers, 1984).

Report of Action Taken

The proposal was sent to the following people asking for feedback and referrals: nine outpatient therapists; the Outpatient Clinical Director; the Director of Children's Psychiatric Services; and the Director of Clinical Services. All agreed it was a good proposal which would probably work. Next the practicum was discussed with other Licensed Mental

Health Therapists who worked with children who liked the idea of a parent educational training group running simultaneously with a group for their children aged 8-12 years old which focused on self esteem. It was explained to the therapists that the parents would be working on parenting and communication skills and that in order to practice these skills as they learned, they could periodically observe their children through the one-way mirror and occasionally join the children's group for live practice with their children. It was hoped that by holding two groups in this manner, not only would the self esteem of the children increase, but the rate of recidivism experienced by these therapists would be greatly reduced. It was hoped that including the parents would reinforce any positive changes occurring in the children. In a burst of cooperation the other therapists deluged this writer with referrals for these groups.

The Piers Harris Children's Self Concept Scale was administered immediately to each referred child. If the child scored below 50 points on the total raw score of the test, he/she was assigned to the children's group on self esteem while their parents were placed in the parent education training group. The groups would meet simultaneously for one and a half hours per week. Since the writer worked with the parents' group he generally followed his calendar plan which included a 32-week lesson plan of

topics which incorporated improving parent/child communication; explaining some various approaches to discipline; encouraging positive reinforcement and praise; and having the parents analyze their feelings and reactions when their children misbehaved.

One unexpected event occurred during the course of this practicum. The Outpatient Clinical Director did not want the writer to exclude any parents from the parent education training group if their child did not score below 50 points on the Piers Harris Children's Self Concept Scale. Therefore, the group was not homogenous; although the children's level of self esteem as measured ranged from 30-70 points, only those scoring below 50 points were considered as participating in the practicum. Another unexpected event involved the overwhelming number of referrals for these groups; this necessitated the formation of a second group for parents and their children.

As these groups progressed the writer found that the parents seemed somewhat resistant to the standard lectures, working in work books, and doing the homework assignments which provided the format for most traditional parent education groups. Each week these parents would bring in real life problems for which they needed practical help. When they began to discuss these problems the other parents became quite supportive, offering suggestions and solutions which they had found useful in dealing with these same

problems with their own children. This writer's position in the group changed from that of teacher to that of active participant in these solution-oriented conversations; he was able to introduce relevant concepts and ideas from the topics covered.

The topics covered included: active listening; conflict resolution; utilizing discipline based on natural and logical consequences; mutual respect and equality; praise and encouragement; violence among children; the effect of parental lifestyles upon children; the impact of parents' families of origin and its influence on their own parenting styles; promoting self esteem in children; developing responsibility in children; relationships and feelings within families; sibling rivalry; helping children to handle fear and understand and accept death within the family; parental guilt, healthy versus unhealthy; and the workings of a democratic family.

The writer combined three parent training programs, selecting parts which focused on communication. These three programs were: Step/Teen: Systematic training for effective parenting of teens (Dinkmeyer and McKay, 1983); Responsive parenting (Lerman, 1989); and Active parenting (Popkin and Garcia, 1983). These parent training programs included the use of both audio and video tapes which presented scenarios of situations which explained and demonstrated the four goals of misbehaving children. They

also demonstrated appropriate responses in dealing with parental challenges.

Homework assignments were given where the parents were asked to look for positive behaviors and practice praise and encouragement throughout the week. They were also asked to be aware of their feelings toward their children when they misbehaved and to try to identify the reason for that misbehavior as: attention seeking; revenge; power; a display of inadequacy; or a combination of these reasons. Once the parents identified the goals of the misbehaving child they could apply methods learned in the parent education group and report during the next session on their successes and/or failures.

One unexpected event that the writer had failed to consider involved the fact that the majority of the parents attending the parent education group sessions came from low socioeconomic groups dependent on welfare; many were uneducated and illiterate. Therefore written homework assignments were completely impractical since most could neither read nor write. Additionally many of these parents were raising emotionally handicapped children and were trying to keep up with many different appointments for counseling, food stamps, and doctors; thus their time was extremely limited. When homework assignments were given the parents would try to remember them and recite their experiences; oftentimes they would fail to do the homework.

These parents also had difficulty relating their personal situations to those demonstrated on tapes due to vast socioeconomic differences and the severity of the problems they were experiencing with their children. In order to compensate for these problems, the writer would tell the parents to watch and listen to the tapes with open minds and try to pick out parts that might be useful for them. Afterwards the writer would engage the parents in discussions about possible ways the parents could use the information in the tapes to their advantage.

To deal with the problems associated with the homework assignments the writer would discuss appropriate behaviors or responses with the parents before taking them into the children's self esteem group to practice what they had just learned. Role playing and live practice proved most interesting and relevant to the parents because of the immediate reinforcement of newly learned coping skills. For example, if a parent was seeking help for dealing with a child's temper tantrum, the writer would introduce into the conversation that temper tantrums are an example of one of the four goals of children's misbehavior. This made the parents regard the writer as a co-collaborator in the conversation introducing new ways of thinking about their problem rather than "teaching" them.

Once the parents had learned some new concepts and ideas, they were allowed to view their children through the

one-way mirror and pick out the positive behaviors demonstrated by their children in the context of the children's group. The parents would then join the children's group and voice encouragement and praise for the positive behaviors exhibited by their children. Direct feedback would then be elicited from both children and parents concerning their feelings as they participated in this process.

Another unexpected event concerned the fact that many parents and children dropped out of both the parents' education training group and the children's self esteem group after four months. Followup calls to the parents indicated that both they and their children were doing well and still improving. The parents reported the reasons for terminating the sessions as either conflicting work schedules, no babysitter, or lack of transportation. However, since the groups were so large, there were plenty of children to continue the practicum.

The responses of the parents to this practicum were extremely positive. Many parents commented on the useful benefits derived from the support of the other parents and the exchange of useful ideas within the group when discussing problems they were experiencing with their children. Other parents commented that since attending the parent training group, their styles of parenting had changed drastically for the better. One parent said that she wished

the parent education group lasted longer because she could continue talking for hours.

This writer particularly enjoyed the practicum experience because he was not placed in an hierarchical role with all the responsibility incumbent with "giving advice" to the parents; instead, as an actual participant in the parent education training group, the therapist himself learned new strategies for dealing with problem children from the parents and thus responsibility for the group was mutually shared.

CHAPTER V

RESULTS, DISCUSSION, AND RECOMMENDATIONS

The problem in the writer's workplace addressed by this practicum concerns the fact that many children, eight through twelve years old, from dysfunctional families who enter counseling suffer from poor self esteem. In order to improve this situation the writer chose to work with the parents of children selected to participate in the practicum while the children attended another therapy group which focused on improving their self esteem. The parents' education group and the children's self esteem group were run simultaneously. Working only with the group of parents whose children who scored below fifty points on the Piers Harris Children's Self Concept Scale, the writer focused on developing more positive parent/child interactions. The format utilized for the parent education training group included lectures, homework assignments, role playing, and videotaped presentations; it also involved the use of a one-way mirror through which the parents observed their children participating in group interaction as well as an opportunity to practice giving their children positive feedback, encouragement, and support when they joined the children's group immediately after their observing them through the mirror.

Results of Expected Outcomes

1. The six children identified for this practicum will, upon its completion, exhibit increased eye contact by making eye contact three or more times with anyone in the group based on clinical check lists (See Appendix A). Additionally, these six children will demonstrate increased eye contact based on the structural interviews with their parents, wherein their parents answer at least "Sometimes" for all five questions on the Likert Scale (See Appendix B).

Child #1 was given the fictional name of "Martha" for identification purposes. In the three observational periods this writer conducted at the end of the practicum Martha scored thirteen eye contacts during the first 15 minutes; four eye contacts during the second 15 minutes; and six eye contacts during the third 15 minutes. The total of 23 eye contacts was 20 more than the three projected by this practicum. On the five structured interview questions about eye contact Martha's mother answered three with Always, one with Usually, and one with Sometimes. The one which was answered Sometimes was, "Does the child make eye contact with other people in general?"

Child #2 was given the fictional name of "Tavaris" for identification purposes. During the first 15 minute observation period Tavaris scored four eye

contacts; during the second 15 minutes, seven eye contacts; and during the final 15 minutes, 17 eye contacts for a total of 24 eye contacts during the final children's group at the end of the practicum. This was 21 contacts over what was projected at the beginning of this practicum. During the structured interview his mother scored him Sometimes on all five questions pertaining to eye contact.

Child #3 was given the fictional name of"Cathy" for the purpose of identification. During the first 15 minute observational this writer observed Cathy making eye contact ten times; during the second 15 minutes, five times; and during the third period, nine times for a total of 24 eye contacts. During the structured interview, her mother scored Cathy 2 Always and 3 Usually on the five eye contact questions.

Child #4 was given the fictional name of"Antwon" for identification purposes. During the first 15 minute observational period this writer observed Antwon making eye contact eight times; during the second 15 minute period, nine times; and during the third observational period, 16 times for a total of 33 eye contacts. During the structured interview his mother scored Antwon Sometimes on all five questions; yet Antwon scored 30 points more than the three eye contacts projected for this practicum.

Child #5 was given the fictional name of"Raishann" for purposes of identification. Raishann was observed making eye contact twelve times during the first 15 minutes; six times during the second 15 minutes; and four times during the third 15 minutes for a total of 22 eye contacts. During the structured interview her mother scored Raishann one Always, one Usually, and three Sometimes on the five questions on eye contact. Yet this child was observed making 19 more eye contacts than projected for this practicum.

Child #6 was given the fictional name of"Patrick". This writer observed Patrick making six eye contacts during the first 15 minutes; four eye contacts during the second 15 minutes; and five eye contacts during the final 15 minute observational period for a total of 15 eye contacts. During the structured interview, Patrick's mother answered Sometimes on all five questions pertaining to eye contact, yet he scored 12 eye contacts more than the projected three.

2. The six children identified for this practicum upon its completion will maintain more positive interaction with family and friends indicating improved social skills based on clinical observation checklists wherein they demonstrate less than five occasions of negative behavior during the group session (See Appendix C). Additionally these six children will demonstrate to

their parents improved social skills as indicated by their parents answering at least Sometimes on all twenty of the structured interview questions. Upon completion of this practicum, the writer administered an individual 30-minute structured interview with each parent who participated in it. During the interview the parents were asked questions concerning the child's eye contact, interactions in the family, and positive social skills. The questions were answered on a five response Likert Scale in which:
1=Never; 2=Seldom; 3=Sometimes; 4=Usually; 5=Always (See Appendix D).

Upon observation for negative behavior by this writer, during the first 15 minute period Raishann demonstrated one incidence of inattentiveness; during the second 15 minutes,none; and during the third 15 minutes, none. During the structured interview her mother answered six questions, Always; four questions, Usually; and ten questions, Sometimes. Raishann demonstrated less than five incidents of negative behavior and her mother scored her Sometimes or better on every structural interview question.

Martha demonstrated no negative behavior during the three 15 minute periods observed by the writer. This was less than the five projected by the practicum. In the structural interview her mother answered 15

questions as Always and five as Usually far exceeding the projection of Sometimes or better on all questions.

Cathy demonstrated no negative behavior during any of the three 15 minute observation periods. During the structured interview her mother answered 17 questions as Always and 3 as Usually, indicating better than the Sometimes projected for all questions.

Patrick was observed by this writer displaying the negative behavior of "lack of cooperation" twice during the first 15 minute observation period and one incident of "inattentiveness" during the third 15 minute period. His scores also fall below the five negative behaviors cutoff indicated in the expected outcomes. During the structured interview Patrick's mother answered 17 questions as Sometimes; 2 as Usually; and one as Always, placing him at or above the Sometimes cutoff.

Tavaris demonstrated two negative behaviors, "inattentiveness" and "withdrawal" during the first 15 minute observation period; one incident of "inattentiveness" during the second 15 minutes; and one incident of "teasing" during the third 15 minutes, placing below the five negative behavior cutoff. During the structured interview his mother rated him 17 as Sometimes; two as Always; and one as Usually, placing him at Sometimes or better in all questions on positive social skills.

Antwon demonstrated no negative behavior during the first 15 minutes; one incident of "inattentiveness" during the second 15 minutes; and three negative behaviors during the third observational period: one incidence of "lack of self control" and two occurrences of "inattentiveness." During the structured interview with his mother, she scored 16 questions as Sometimes; one as Usually; and three as Always. Antwon demonstrated five or less occurrences of negative behavior and scored Sometimes or better on all the structured interview questions.

3. The six children identified for this practicum will, upon its completion, demonstrate in writing that they can list at least three positive attributes about themselves.

Upon completion of the practicum, the children were asked to list in writing as many positive things about themselves as possible. This was to determine whether the children would list more or less than the three positive things required for expected practicum outcomes.

Raishann, when asked to list three or more positive things about herself, listed seven.

Tavaris, when asked to list three or more positive things about himself, listed ten.

Cathy, when asked to list three or more positive things about herself, listed seven.

Martha, when asked to list three or more positive things about herself, listed seven.

Antwon, when asked to list three or more positive things about himself, listed four.

Patrick, when asked to list three or more positive things about himself, listed five.

4. The six children identified for this practicum will, upon its completion, indicate a five to ten point increase in global self esteem as measured by the Piers Harris Children's Self Concept Scale.

The children selected for this practicum all scored less than 50 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum the Piers Harris Children's Self Concept Scale was readministered to the children who participated in the practicum. The two sets of raw scores were compared to determine whether the children showed an increase or decrease in their global self esteem scores.

Cathy scored 47 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum she achieved a raw score of 75, demonstrating a 28 point increase in her global self esteem.

Martha scored 40 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum she achieved a raw score of 67, demonstrating a 27 point increase in her global self esteem.

Patrick scored 41 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum he achieved a raw score of 63, demonstrating a 22 point increase in his global self esteem.

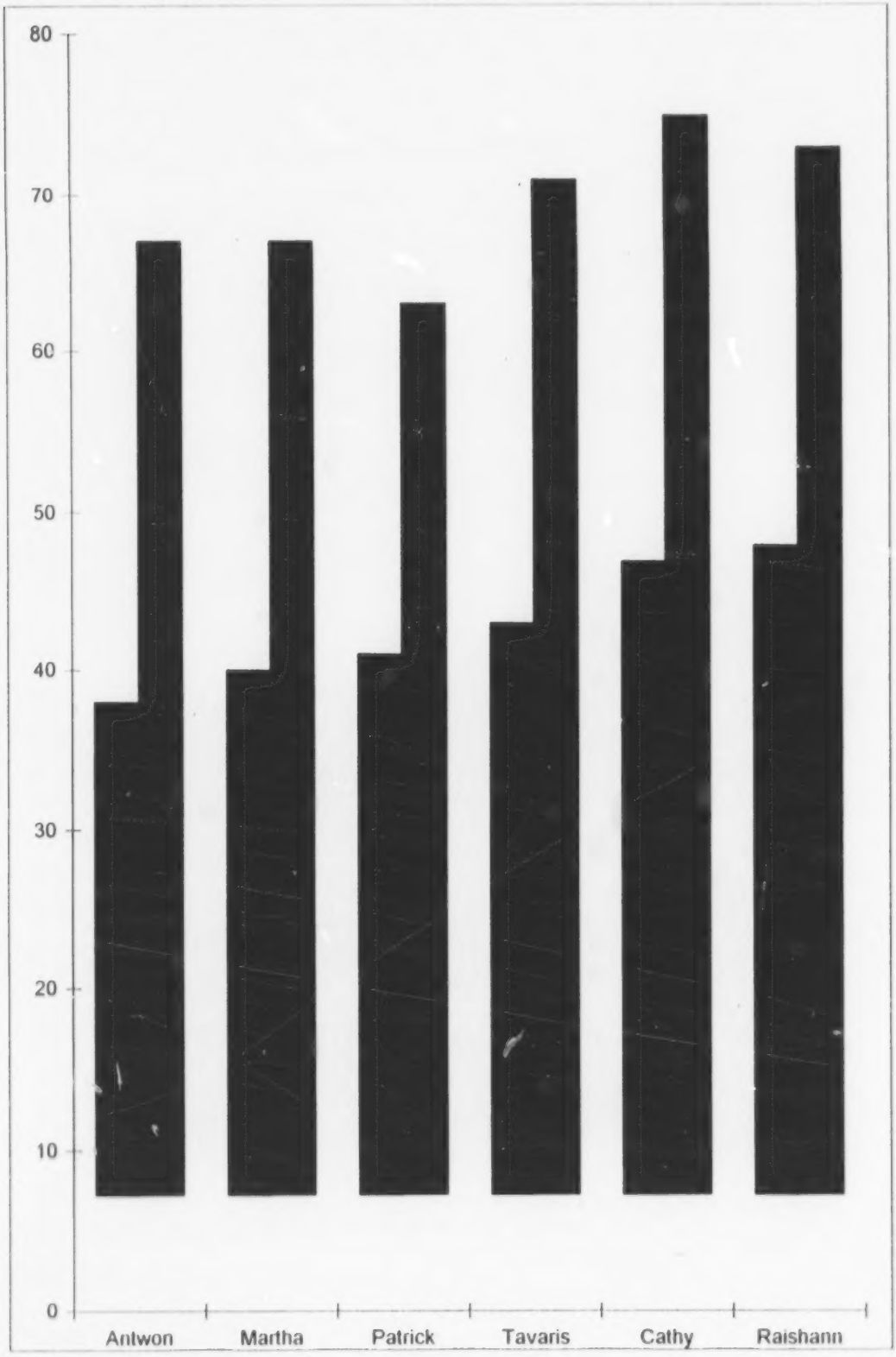
Antwon scored 38 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum he achieved a raw score of 67, demonstrating a 29 point increase in his global self esteem.

Tavaris scored 43 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum he achieved a raw score of 71, demonstrating a 28 point increase in his global self esteem.

Raishann scored 48 as a raw score on the Piers Harris Children's Self Concept Scale at the beginning of the practicum. Upon completion of the practicum she achieved a raw score of 73, demonstrating a 25 point increase in her global self esteem.

PRE- AND POST-TEST RESULTS ON PIERS HARRIS CHILDREN'S SELF CONCEPT SCALE

50



GRAPH

Discussion

The results of this practicum seem to validate the findings of other researchers who have identified a correlation between a child's self esteem and the influence of the parental unit (LeCroy, 1988; Felson and Zielinski, 1989; Demo et al., 1987; and Schickendanz et al., 1990). The results of this practicum also indicate that training parents to use positive communication skills, praise and encouragement, and authoritative discipline in dealing with their child significantly impacts on that child's self esteem. This has been substantiated by the work of researchers such as Eyberg and Robinson (1992) who found that teaching parents of dysfunctional families such skills as giving positive attention and praise with a minimum of correction and criticism could change the interactional style and behavior of their children. LeCroy (1988) further states that programs designed to increase intimacy in the parental/adolescent relationship would be beneficial in increasing self esteem in children.

The strongest premise upon which this writer bases the positive outcomes of this practicum originates with the social constructivist view that one's sense of self, including self esteem, is constantly being socially reconstructed through language with others. According to Shotter (1985) self esteem is a hermeneutic process in which self concept is revealed through conversations with others

and how we perceive that others perceive us through language. Since language constitutes the expression of our being, through language we ourselves are constantly changing within ever-changing contexts. Gergen (1991) similarly expounds on the theory that self concept changes in sheer reaction to the positive or negative remarks made by the people with whom one is associated. This practicum attempted to help parents of dysfunctional families change their patterns of communication and interaction with their 8-12 year old children; as these parents focused more on positive communication, their children's self esteem increased dramatically.

From a systemic viewpoint, this practicum has powerful implications. Previously children from dysfunctional families would improve their self esteem through counseling; then the counseling would be terminated and the children would return to a dysfunctional family who had received little or no treatment. After several months in the same environment which originally caused their lack of self esteem, these same children would reappear for counseling, again exhibiting the same symptoms of poor self esteem. Teaching the parents different, more positive ways of communicating and interacting with their children changed the entire familial system and subsequently increased not only the child's self esteem, but also that of the entire family.

All the outcomes of this practicum were met, not just barely, but quite significantly. This indicates the great potential of successfully treating low self esteem in children by counseling both the parents and the children. By helping parents improve their communication and interaction with their children it is actually possible to increase the self esteem of children, aged 8-12, from dysfunctional families.

Recommendations

1. The parent education training group should be shorter in length, probably around 16 sessions to decrease the number of dropouts.
2. In training the parents a co-collaborative, solution-based approach should be adopted by the group leader rather than the more traditional teacher/pupil approach. A leader who becomes a participant can encourage longer conversations with the parents as well as create a more comfortable context of learning while still introducing new concepts and ideas.
3. The parent education training group and the children's self esteem group should be conducted simultaneously so that parents can practice their newly-acquired skills immediately with their children in the presence of the counselor. This situation lends itself nicely to the

other parents and the group leader acting as coaches on the correct way to practice the new behaviors.

4. The more parental figures involved in the parent training group, the better it will function. Grandparents, step parents, significant others, babysitters, and friends all play important roles in children's lives and should be invited to participate; this will help provide consistency in the children's lives.

Dissemination

Upon approval of this practicum, copies will be distributed to the Director of Services for the psychiatric hospital, the Director of Outpatient Services, and all the therapists in the outpatient clinic who work with children. This practicum has also been submitted for presentation at the Seventh World Congress on Family Therapy to be held in Guadalajara, Mexico in October, 1995. Lastly, this practicum will continue to be practiced at this writer's work place.

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APPENDIX A

METHOD OF RECORDING EYE CONTACT

METHOD OF RECORDING EYE CONTACT

In order to measure the frequency of eye contact each child makes with his/her peers and group leader, the observing therapist will count occurrences of such eye contact at the end of the practicum. A 15-minute observation period will occur at the beginning, middle, and end of this group session.

The therapist will add the number of eye contacts made by each individual child during three 15-minute periods throughout the entire group session on observation day. The traditional stroke tally method will be used to measure the frequency of behavior (ie., each stroke mark will indicate one occurrence of direct eye contact per child).

APPENDIX B

STRUCTURED INTERVIEW QUESTIONS ON CHILD'S EYE CONTACT

STRUCTURED INTERVIEW QUESTIONS ON CHILD'S EYE CONTACT

Eye contact will be defined as occurring when the child, identified as the subject, looks directly at another individual with whom he/she is speaking or interacting.

1) Does the child make eye contact with you, the parent (mother, father, caregiver):

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

2) Does the child make eye contact with his peers (friends, playmates):

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

3) Does the child make eye contact with his/her siblings (brothers, sisters, stepbrothers, step-sisters, half brothers, half sisters):

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

4) Does the child make eye contact with his/her relatives (grandparents, uncles, aunts, cousins):

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

5) Does the child make eye contact with other people in general:

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

APPENDIX C

OBSERVATIONAL CHECKLIST

OBSERVATIONAL CHECKLIST

The following negative social interaction behaviors will also be counted using the traditional stroke tally method for three 15-minute observation periods during the play therapy group sessions at the end of this practicum. The therapist observer will remain anonymous by means of a one-way mirror which will be utilized in observing the following negative interactive behaviors:

1) Aggression;
2) Lack of cooperation;
3) Teasing;
4) Selfishness;
5) Inattentiveness;
6) Withdrawal;
7) Defiance;
8) Argumentativeness;
9) Lack of self control;
10) Anger.

APPENDIX D

STRUCTURED INTERVIEW QUESTIONS ON FAMILY INTERACTION AND POSITIVE SOCIAL SKILLS

STRUCTURED INTERVIEW QUESTIONS ON FAMILY INTERACTION AND POSITIVE SOCIAL SKILLS

Positive social skills and family interaction will be defined to the parents as the ability to interact in a positive social way with parents, siblings, relatives, peers and persons in authority in a manner which allows the child to be assertive while, at the same time, respecting the rights and privileges of others.

1) The child enjoys working with others (ie., child seems content when engaged in productive group activity).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

2) The child tends to show respect for adults (ie., child does not talk back, refuse to obey or balk in the presence of adults).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

3) The child appears sociable (ie., does not prefer to play and work alone and does not leave setting or activity when others join in).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

4) The child is friendly (ie., does not work and play alone, leave activity when others join in, nor refuse friendly overtures).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

5) The child shows respect and consideration for peers (ie, does not try to dominate or bully, lead against the desire of the group, or force himself/herself, either verbally or physically, on others.

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

6) The child avoids fighting.

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

7) The child displays consideration in talking (ie, does not talk compulsively or interrupt others and waits his/her time to talk; does not need to have last word with peers and adults).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

8) The child interacts amicably (ie., does not reject criticism and does not express defiance either verbally through sassiness nor non-verbally through such physical actions as tearing up work, destroying game, disrupting group activity and fighting).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

9) The child readily accepts blame when at fault.

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

10) The child is trusting (ie., has unquestioning reliance in statements, actions, and justice of others and is not suspicious of others).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

11) The child seems to behave in an agreeably confident manner (ie., does not have a "chip" on his/her shoulder and does not misinterpret expressed thoughts, motives, and actions of others as being opposed to the child's best interests).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

12) The child is friendly (ie., is not quarrelsome or argumentative and does not taunt and/or continuously disagree with others.

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

13) The child gets along well with others (ie., does not provoke hostility in peers and/or siblings or tease others verbally or non-verbally).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

14) The child can solve problems and keep things to him/herself (ie., does not tattle or tell parents and/or others statements and actions which were not intended for others to know about).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

15) The child maintains a comfortable space between self and others (ie., does not get into faces of others).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

16) The child demonstrates appropriate voice quality for situation (ie., does not talk rudely or sarcastically and does not shout inappropriately).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

17) The child shares (ie., allows others to play with toys and engage in activities with him/her).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

18) The child acts modestly (ie., does not brag excessively about achievements, skills, or appearance).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

19) The child engages in appropriate physical contact (ie., does not engage in inappropriate touching or physical contact with others).

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5

20) The child is charitable (ie., does not display jealousy over attention paid to peers or siblings.

Never	Seldom	Sometimes	Usually	Always
1	2	3	4	5